

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film 6209 1-4-51 et

12485

CERTIFICATE OF DEATH

12441

Reg. Dist. No. 145

| | | | | | | | |
|---|-------------------------------|--|------------------------------|---|-----------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Frederick</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Myersville</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Myersville</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>B.</u> Last <u>Baker</u> | | | | 4. DATE OF DEATH Month <u>12</u> Day <u>23</u> Year <u>1956</u> | | | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1904</u> | 9. AGE (In years last birthday) <u>52</u> yrs. | IF UNDER 1 YEAR | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>general laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>bakery</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>James E. Baker</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Etta Summers</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>213-14-0396</u> | | 17. INFORMANT <u>Mrs. Jean Baker, Myersville Md.</u> Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>14 hrs</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Dec 22</u> , 19 <u>56</u> , to <u>Dec 23</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 22</u> , 19 <u>56</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE <u>J Elmer Harp</u> M.D. | | | | MIDDLETOWN | | | |
| PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>12/26/56</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Ch. B. Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Harmony (Fred. Co.) Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Gladhill Co.</u> ADDRESS <u>Middletown, Md.</u> | | | | 24a. REC'D BY REGISTRAR <u>DATE 12-26-56</u> | | 24b. REGISTRAR'S SIGNATURE <u>Floyd M. Bittel</u> | |

CERTIFICATE OF DEATH

[Faint, mostly illegible handwritten text on the certificate form, including fields for name, date, and cause of death.]

BUREAU V. S.

DEC 28 1956

RECEIVED

12436

CERTIFICATE OF DEATH

Reg. Dist. No. 138

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#6 | | | | c. LENGTH OF STAY IN 1b 3 Months | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bartonsville Road | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First LINDA Middle ANN Last BARTLETT | | | | 4. DATE OF DEATH Month December Day 31 Year 19 56 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 24 Sept 1956 | |
| 9. AGE (In years last birthday) yrs. 3 | | IF UNDER 1 YEAR Months 7 Days 9 Hours Min. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant | | 10b. KIND OF BUSINESS OR INDUSTRY Maryland | |
| 11. BIRTHPLACE (State or foreign country) USA | | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME James C. Bartlett | | | | 14. MOTHER'S MAIDEN NAME Florence Trout | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT James C. Bartlett (Same as item #1) | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho Pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH 5 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) Frederick, Maryland | | | | 20g. (County) (State) | | | |
| 21. I certify that I attended the deceased from 12-28 , 19 56 , to 12-31 , 19 56 , that I last saw the deceased alive on 12-31 , 19 56 , and that death occurred at 11:30 PM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE M. G. Bourne Jr. | | | | ADDRESS (Street, city or town, state) 30 W. All Saints St., Fred'k, Md. | | | |
| DATE SIGNED 1/2/57 | | | | | | | |
| PHYSICIAN'S NAME (Type) U. G. Bourne, Jr., M. D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 2 Jan 1957 | | 22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery | | 22d. LOCATION (City, town, or county) (State) Frederick, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison and Son, Frederick, Maryland | | | | ADDRESS Frederick, Maryland | | 24a. REC'D BY REGISTRAR DATE Jan 2-57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Lucas K. Telcom | | | |

2069254XV6

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1957 7 JAN

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12443

12458 CERTIFICATE OF DEATH

Reg. Dist. No.

131

| | | | | | | | |
|---|----------------------------------|---|---------------------------------------|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | | | c. LENGTH OF STAY IN 1b Frederick-Rural RD#1 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital | | | | d. STREET ADDRESS Daysville Road | | | |
| e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First JAMES Middle CALVIN Last BEARD | | | | 4. DATE OF DEATH Month December Day 23 Year 1956 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7 Nov 1879 | 9. AGE (In years last birthday) 77 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Farm Owner | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME John D. Beard | | | | 14. MOTHER'S MAIDEN NAME Barbara Spurrier | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. Unk | | 17. INFORMANT Mrs. Myrtle Crum Beard Address (Same as item #2) | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 17 hours | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Duodenal ulcer (bleeding) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Dec. 17 , 19 56 , to Dec. 23 , 19 56 , that I last saw the deceased alive on Dec. 23 , 19 56 , and that death occurred at 1:50 P.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Bernard O. Thomas Jr. | | | | ADDRESS (Street, city or town, state) DATE SIGNED 228 N. Market St., Frederick, Md. 12/26/56 | | | |
| PHYSICIAN'S NAME (Type) Bernard O. Thomas, Jr., M. D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 26 Dec 1956 | | 22c. NAME OF CEMETERY OR CREMATORY Chapel Cemetery | | 22d. LOCATION (City, town, or county) (State) Nr. Libertytown, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland | | | | 24a. REC'D BY REGISTRAR DATE 27 Dec 1956 | | 24b. REGISTRAR'S SIGNATURE Elizabeth H. Hark | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|-------------------------------|--|-------------------------------|--|--------------------------|--|------------------------------|--|-------------------------------|--|-------------------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF DEATH | | PLACE OF DEATH | |
| JAMES EARL RAY | | 35 | | M | | W | | 12-13-68 | | MEMPHIS, TENN. | |
| BIRTH DATE | | BIRTH PLACE | | MARRIED | | OCCUPATION | | CAUSE OF DEATH | | MANNER OF DEATH | |
| 05-19-33 | | MEMPHIS, TENN. | | YES | | COUNSELLOR | | HEART DISEASE | | SUICIDE | |
| FATHER'S NAME | | MOTHER'S NAME | | EDUCATION | | RELIGION | | SIGNS AND SYMPTOMS | | TREATMENT | |
| JAMES EARL RAY | | LUCILLE RAY | | HIGH SCHOOL | | METHODIST | | PAIN IN CHEST | | NO | |
| PREVIOUS ILLNESS | | PREVIOUS SURGERY | | PREVIOUS TRAUMA | | PREVIOUS DRUGS | | PREVIOUS ALCOHOL | | PREVIOUS TOBACCO | |
| NO | | NO | | NO | | NO | | NO | | NO | |
| PREVIOUS MENTAL ILLNESS | | PREVIOUS PHYSICAL ILLNESS | | PREVIOUS SOCIAL ILLNESS | | PREVIOUS ECONOMIC ILLNESS | | PREVIOUS POLITICAL ILLNESS | | PREVIOUS CULTURAL ILLNESS | |
| NO | | NO | | NO | | NO | | NO | | NO | |
| PREVIOUS LEGAL ILLNESS | | PREVIOUS CRIMINAL RECORD | | PREVIOUS CIVIL RECORD | | PREVIOUS JUDICIAL RECORD | | PREVIOUS LEGAL COUNSEL | | PREVIOUS LEGAL REPRESENTATIVE | |
| NO | | NO | | NO | | NO | | NO | | NO | |
| PREVIOUS MENTAL HEALTH CARE | | PREVIOUS PHYSICAL HEALTH CARE | | PREVIOUS SOCIAL WORK | | PREVIOUS ECONOMIC ASSISTANCE | | PREVIOUS POLITICAL ACTIVITIES | | PREVIOUS CULTURAL ACTIVITIES | |
| NO | | NO | | NO | | NO | | NO | | NO | |
| PREVIOUS LEGAL REPRESENTATIVE | | PREVIOUS LEGAL COUNSEL | | PREVIOUS LEGAL ASSISTANT | | PREVIOUS LEGAL CLERK | | PREVIOUS LEGAL RESEARCHER | | PREVIOUS LEGAL WRITER | |
| NO | | NO | | NO | | NO | | NO | | NO | |

BUREAU V. S.

DEC 28 1956

RECEIVED

12459 CERTIFICATE OF DEATH

Reg. Dist. No.

131

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> | | c. LENGTH OF STAY IN 1b <u>Rt #1</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u> | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) <u>Donald</u> First <u>Blaine</u> Middle <u>Burkett</u> Last | | 4. DATE OF DEATH <u>December 11</u> Year <u>1956</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>December 10, 1956</u> |
| 9. AGE (In years last birthday) <u>15</u> yrs. | | IF UNDER 1 YEAR: Months <u>15</u> Days <u>30</u> IF UNDER 24 HRS. Hours <u>15</u> Min. <u>30</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Bernard Edward Burkett Jr.</u> | | 14. MOTHER'S MAIDEN NAME <u>Gladys Isabel Morgan</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Mr. Bernard E. Burkett, Frederick R.D.#1, Md.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH <u>15 hr. 30 min.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Dec. 10</u> 19 <u>56</u> , to <u>Dec. 11</u> 19 <u>56</u> , that I last saw the deceased alive on <u>Dec. 10</u> 19 <u>56</u> , and that death occurred at <u>5:30 A.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Robert S. Turner Jr.</u> M.D. | | ADDRESS (Street, city or town, state) <u>7 E. CHURCH ST.</u> DATE SIGNED <u>12-11-56</u> | |
| PHYSICIAN'S NAME (Type) <u>Dr. Robert S. Turner Jr.</u> | | <u>Frederick, Maryland</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>Dec. 12, 1956</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Etchison & Son, Frederick, Maryland</u> | | 24a. REC'D BY REGISTRAR <u>Elizabeth B. Heck</u> 24b. REGISTRAR'S SIGNATURE | |

2269285XVI

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

BUREAU V. 5

DEC 17 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12460 CERTIFICATE OF DEATH

Reg. Dist. No. 12445-131

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u> | | c. LENGTH OF STAY IN 1b <u>Frederick R #1</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <u>FREDERICK MEMORIAL HOSPITAL</u> | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Ronald Wayne Burkett</u> | | 4. DATE OF DEATH Month Day Year <u>December 12 1956</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>December 10, 1956</u> |
| 9. AGE (in years last birthday) yrs. <u>43</u> | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Bernard Edward Burkett Jr.</u> | | 14. MOTHER'S MAIDEN NAME <u>Gladys Isabel Morgan</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Mr. Bernard E. Burkett, Frederick R.D. #1, Md.</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH <u>43 hrs.</u> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>12-10</u> , 19 <u>56</u> , to <u>12-12</u> , 19 <u>56</u> ; that I last saw the deceased alive on <u>12-11</u> , 19 <u>56</u> , and that death occurred at <u>7:00 PM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Robert S. Turner Jr.</u> M.D. | | ADDRESS (Street, city or town, state) <u>7 E. CHURCH ST.</u> DATE SIGNED <u>12-12-56</u> | |
| PHYSICIAN'S NAME (Type) <u>Rev. Robert F. Turner Jr.</u> | | <u>Frederick, Maryland</u> | |
| 22a. BURIAL, CREMATION, or other disposition (specify) <u>Burial</u> | 22b. DATE THEREOF <u>Dec. 12, 1956</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Etchison & Son, Frederick, Maryland</u> | | 24a. REC'D BY REGISTRAR <u>DATE 12 Dec 1956</u> | 24b. REGISTRAR'S SIGNATURE <u>Elizabeth G. Herb</u> |

2169284 XVI

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 2

DEC 17 1956

RECEIVED

12461 CERTIFICATE OF DEATH

12446

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|---|--------------------------------------|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived 11 institution Residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural (New addition) Brunswick | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Dead on Arrival Frederick Hospital | | | | d. STREET ADDRESS - | | | |
| 3. NAME OF DECEASED (Type or print) First John Middle Thomas Last Carey | | | | 4. DATE OF DEATH Month 12 Day 8 Year 1956 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1-22-1898 | | 9. AGE (In years last birthday) 58 yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Car Inspector | | 10b. KIND OF BUSINESS OR INDUSTRY B.&O.R.R.Co | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John T. Carey Sr. | | | | 14. MOTHER'S MAIDEN NAME Mary Gosnell | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. No | | 17. INFORMANT Address Mrs. Eva Carey, Knoxville, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 hrs |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 12-8-1956 , to 12-8-1956 that I last saw the deceased alive on 12-8-1956 , and that death occurred at 5 p. M. from the causes and on the date stated above. ADDRESS (Street, city or town, State) Brunswick, Md DATE SIGNED 12-8-56 | | | | | | | |
| ACTUAL SIGNATURE [Signature] M.D. [Signature] | | | | PHYSICIAN'S NAME (Type) [Signature] | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 12-11-56 | | 22c. NAME OF CEMETERY OR CREMATORY Brethern | | 22d. LOCATION (City, town, or county) (State) Brunsville, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE B. Lee Felt | | | | ADDRESS Brunswick, Maryland | | 24a. REC'D BY REGISTRAR DEC 13 1956 | |
| | | | | 24b. REGISTRAR'S SIGNATURE [Signature] | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

EC 1950

RECEIVED

12462

CERTIFICATE OF DEATH

Reg. Dist. No. 131

| | | | | |
|---|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> | | c. LENGTH OF STAY IN 1b <u>Several Years</u> | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Frederick Memorial Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>HAROLD</u> <u>Chase, III</u> | | 4. DATE OF DEATH Month Day Year <u>December 20, 1956</u> | | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Dec. 20, 1956</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) yrs Months Days Min <u>15</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | |
| 13. FATHER'S NAME <u>Harold Chase, II.</u> | | 14. MOTHER'S MAIDEN NAME <u>Carole M Shockley</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | |
| 17. INFORMANT <u>Harold Chase, II. (Same as item #2)</u> | | Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> 776 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Dec 20, 1956</u> to <u>Dec 20, 1956</u> , that I last saw the deceased alive on <u>Dec 20, 1956</u> , and that death occurred at <u>12:30 A.M.</u> from the causes and on the date stated above. | | | | |
| ACTUAL SIGNATURE <u>Robert S. Turner, Jr.</u> M.D. | | ADDRESS (Street, city or town, state) <u>7 E. Church St. Frederick, Md.</u> DATE SIGNED <u>12-20-56</u> | | |
| PHYSICIAN'S NAME (Type) <u>Robert S. Turner, Jr., M. D.</u> | | <u>7 E. Church St., Frederick, Md.</u> | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>21 Dec 1956</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Etchison and Son, Frederick, Maryland</u> | | 24a. REC'D BY REGISTRAR <u>DATE 21 Dec 1956</u> | 24b. REGISTRAR'S SIGNATURE <u>Elizabeth G. Herb</u> | |

2009203XVO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

REC 20 1900

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12448

Reg. Dist. No. 131

12463

| | | | | | | | |
|---|--|---|----------------------------------|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | | c. LENGTH OF STAY IN 1b Years | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Fort Detrick | | | | d. STREET ADDRESS 157 West Patrick Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First HOWARD Middle SYLVESTER Last COLLIFLOWER, SR. | | | | 4. DATE OF DEATH Month December Day 3 Year 19 56 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 13 April 1893 | |
| 9. AGE (In years last birthday) 63 yrs. | | IF UNDER 1 YEAR Months 63 Days 63 Hours 63 Min. 63 | | IF UNDER 24 HRS. Months 63 Days 63 Hours 63 Min. 63 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter | | 10b. KIND OF BUSINESS OR INDUSTRY U. S. Army Camp | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Howard Franklin Colliflower | | | | 14. MOTHER'S MAIDEN NAME Emma Jane Miller | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 214-10-5860 | | 17. INFORMANT Address Mrs. Nellie J. Colliflower (Same as Item #2) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (b) 100% (c) 100% DUE TO cause lost, (c) 100% | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 Hour |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 27. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE B. O. Thomas | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) B. O. Thomas, M. D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6 Dec 1956 | | 22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery | | 22d. LOCATION (City, town, or county) (State) Frederick, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS M. R. Etchison & Son, Frederick, Maryland | | | | 24a. REC'D BY REGISTRAR DATE 6 Dec 1956 | | 24b. REGISTRAR'S SIGNATURE Elizabeth H. Hark | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

U. S. DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY
WASHINGTON, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12464

CERTIFICATE OF DEATH

12449

Reg. Dist. No. 131

| | | | | | | | |
|---|----------------------------------|---|---|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 227 East Church Street | | | | d. STREET ADDRESS 227 East Church Street | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last RUDOLPH WILLIAM CROUSE | | | | 4. DATE OF DEATH Month Day Year December 19, 1956 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH September 14, 1872 | 9. AGE (In years last birthday) yrs. 84 | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk (Retired) | | 10b. KIND OF BUSINESS OR INDUSTRY Notions Store | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME William Francis Crouse | | | | 14. MOTHER'S MAIDEN NAME Mary Elizabeth Niedhardt | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 214-10-1387 | | 17. INFORMANT Mrs. Robert H. Hartman, 632 Trail Avenue, Frederick, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC MYOCARDITIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from Dec. 19, 1956 to Dec. 19, 1956 , that I last saw the deceased alive on Dec. 19, 1956 , and that death occurred at 2:40 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <i>[Signature]</i> | | | | ADDRESS (Street, city or town, state) DATE SIGNED East Church St., Frederick, Md. 12/20/1956 | | | |
| PHYSICIAN'S NAME (Type) Dr. H. J. Slusher | | | | Same as above | | | |
| 22a. BURIAL, CREMATION, REINTERMENT (Specify) Burial | | 22b. DATE THEREOF Dec. 22, 1956 | | 22c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery | | 22d. LOCATION (City, town, or county) (State) Frederick, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland | | | | 24a. REC'D BY REGISTRAR DATE 21 Dec 1956 | | 24b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | |

RECEIVED

DEC 26 1956

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
 TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12465

CERTIFICATE OF DEATH

12451b1
 Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|--|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | | |
| c. LENGTH OF STAY IN 1b 12 Years | | | | d. STREET ADDRESS 561 East Church Street | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 561 East Church Street | | | | • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First FLORENCE Middle ARMENTA Last ESWORTHY | | 4. DATE OF DEATH Month December Day 10 Year 1956 | | | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH October 5, 1874 | 9. AGE (In years last birthday) 82 yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Teacher | | 10b. KIND OF BUSINESS OR INDUSTRY Public Schools | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME John H. Harbaugh | | | | 14. MOTHER'S MAIDEN NAME Martha Brown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Mr. C. Oliver Esworthy, 561 East Church Street, Frederick, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic Myocarditis 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 6 Years | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June 1, 1950 to December 10, 1956 , that I last saw the deceased alive on December 10, 1956 , and that death occurred at 10:15 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) East Church St., Frederick, Md. DATE SIGNED 12/11/1956 ACTUAL SIGNATURE H. J. Slusher M.D. PHYSICIAN'S NAME (Type) Dr. H. J. Slusher Same as above | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Dec. 13, 1956 | | 22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery | | 22d. LOCATION (City, town, or county) (State) Frederick, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland | | | | 24a. REC'D BY REGISTRAR 12 Dec. 1956 | | 24b. REGISTRAR'S SIGNATURE Elizabeth S. Herb | |

BUREAU V. S.

DEC 12 1956

RECEIVED

12451/

12487

MEDICAL CERTIFICATION

VS. AISME(S)
SM 9/55

BUCKET A

DEC 10

1944

12456

CERTIFICATE OF DEATH

Reg. Dist. No.

12452

| | | | | | | | |
|---|--|--|--|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | | | c. LENGTH OF STAY IN 1b 1 Day | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jefferson | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) Frederick Memorial Hospital | | | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last GENEVIEVE IRENE FERRELL | | | | 4. DATE OF DEATH Month Day Year December 8, 1956 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 16 Oct 1899 | |
| 9. AGE (In years last birthday) 57 yrs | | IF UNDER 1 YEAR Months Days Hours Min | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work | | | | 10b. KIND OF BUSINESS OR INDUSTRY At Home | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 13. FATHER'S NAME Unknown | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. Unk | | 17. INFORMANT Address Charles F. Ferrell, Jefferson, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE MIAMI DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 24 Hours 3-4- Years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a m. p. m. 19 | | | | 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State) | |
| 21. I certify that I attended the deceased from December 8, 1956 to December 8, 1956 , that I last saw the deceased alive on December 8, 1956 , and that death occurred at 11:40 P M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Henry V. Chase M.D. | | | | ADDRESS (Street, city or town, state) 4 E. Church St. | | DATE SIGNED 8 Dec 1956 | |
| PHYSICIAN'S NAME (Type) Henry V. Chase, M. D. | | | | Frederick, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 12 Dec 1956 | | 22c. NAME OF CEMETERY OR CREMATORY Reformed Cemetery | | 22d. LOCATION (City, town, or county) (State) Jefferson, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland | | | | ADDRESS | | 24a. REC'D BY REGISTRAR DATE 12 Dec 1956 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Elyzabeth B. Heide | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 13

CERTIFICATE OF DEATH

12453

Reg. Dist. No. 131

| | | | | | | | |
|---|----------------------------------|---|--|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rocky Ridge | | | | c. LENGTH OF STAY IN 1b 70 yrs. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First GEORGE Middle WASHINGTON Last FOX | | | | 4. DATE OF DEATH Month Dec. Day 11 Year 1956 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec. 18, 1861 | | 9. AGE (In years last birthday) 95 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance | | 10b. KIND OF BUSINESS OR INDUSTRY West. Md. RR | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John Fox | | | | 14. MOTHER'S MAIDEN NAME Elizabeth J. Biggs | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) No | | 16. SOCIAL SECURITY NO. (If yes, give year or dates of service) | | 17. INFORMANT Address Lester W. Fox Rocky Ridge, Md | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arterosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from Jan 1, 1956 to Dec 11, 1956 , that I last saw the deceased alive on Dec 9, 1956 , and that death occurred at 5:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) W R Cadde Emmitsburg Md DATE SIGNED 12-11-56 ACTUAL SIGNATURE W R CADDE M.D. Emmitsburg Md PHYSICIAN'S NAME (Type) W R CADDE | | | | | | INTERVAL BETWEEN ONSET AND DEATH 15 years | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 22b. DATE THEREOF 12-14-56 | | 22c. NAME OF CEMETERY OR CREMATORY Church of Brethern | |
| 22d. LOCATION (City, town, or county) (State) Rocky Ridge, Maryland | | | | 24a. REC'D BY REGISTRAR Raymond S. Tucker | | 24b. REGISTRAR'S SIGNATURE Thurmont, Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Raymond S. Tucker | | | | 24a. REC'D BY REGISTRAR 13 Dec. 1956 | | 24b. REGISTRAR'S SIGNATURE Elizabeth S. Hecks | |

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 17 1956

RECEIVED

12489

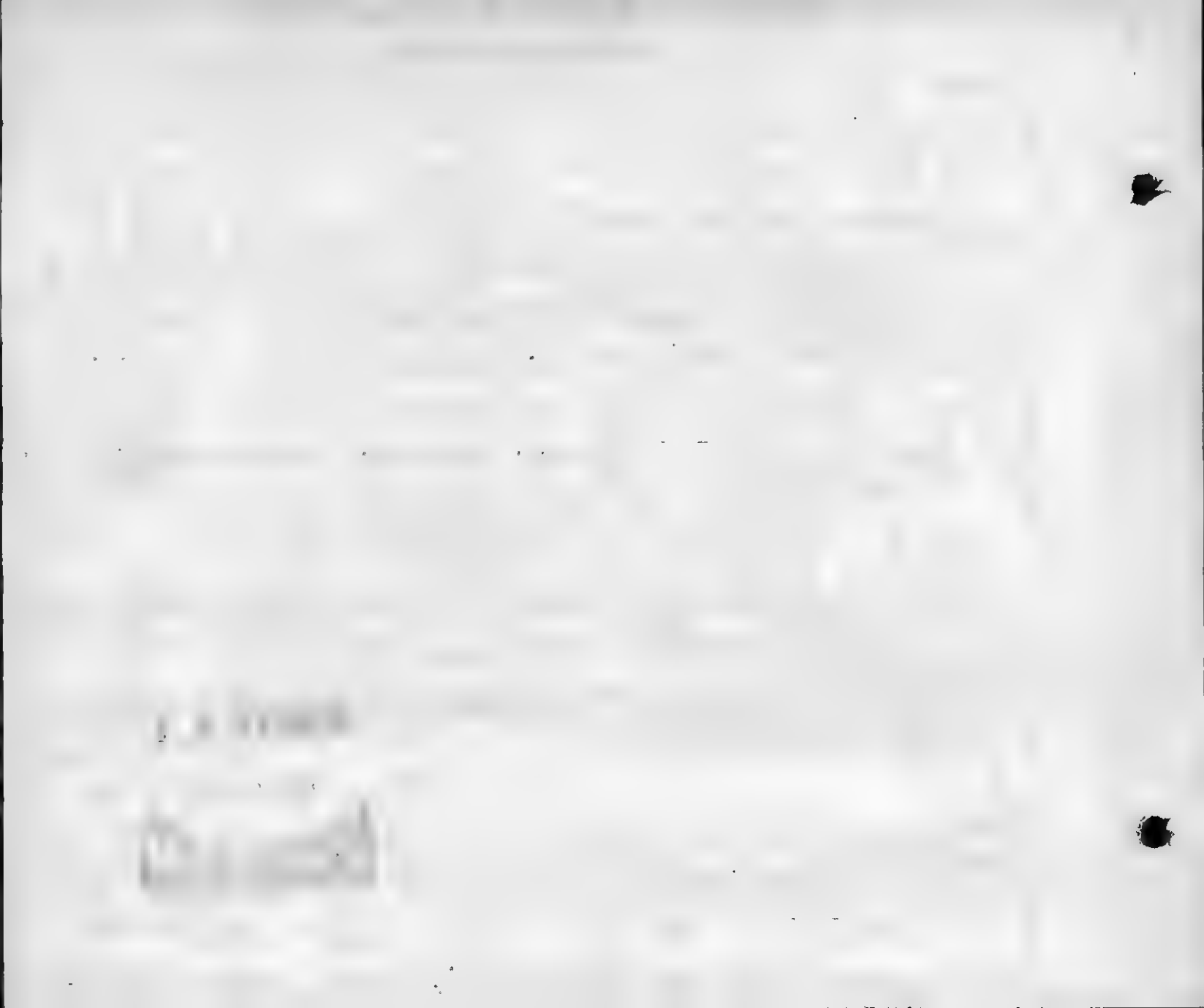
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|--------------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Thurmont | | c. LENGTH OF STAY IN 1b 50-yw | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS Rural Thurmont | |
| 3. NAME OF DECEASED (Type or print) First Lee Middle Roy Last Freshman | | 4. DATE OF DEATH Month December Day 26 Year 1956 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED XX DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH October 25, 1883 |
| 9. AGE (In years last birthday) 73 yrs | | 10. IF UNDER 1 YEAR Months 73 Days 73 Hours 73 Min 73 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Heat Treater Fore. | | 10b. KIND OF BUSINESS OR INDUSTRY Landis Mch. Co. | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME George Freshman | | 14. MOTHER'S MAIDEN NAME Catherine Wilhide | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No | | 16. SOCIAL SECURITY NO. 216-05-1048 | |
| 17. INFORMANT Mr. Burnell R. Freshman | | Address Thurmont, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) General Septicemia 450.1 DUE TO Gangrene of leg- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO Terminal arterio-sclerotic changes PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Multiple sclerosis | | INTERVAL BETWEEN ONSET AND DEATH 11 days 4 wks 6 mos | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) D | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) D | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Nov. 10, 1956 to Dec. 26, 1956 , that I last saw the deceased alive on Dec. 10, 1956 , and that death occurred at 6:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Thurmont, Md. DATE SIGNED James K. Gray | | | |
| ACTUAL SIGNATURE James K. Gray | | M.D. Thurmont, Md. | |
| PHYSICIAN'S NAME (Type) James K. Gray | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 12-29-56 | 22c. NAME OF CEMETERY OR CREMATORY Pipe Creek Cemetery | 22d. LOCATION (City, town, or county) (State) Carroll Co. Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE Thurmont, Md. | | 24a. REC'D BY REGISTRAR 231-11 | |
| 24b. REGISTRAR'S SIGNATURE Eugene H. Hick | | 24c. REGISTRAR'S SIGNATURE E. J. | |

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12457

CERTIFICATE OF DEATH

12455 31
Reg. Dist. No.

| | | | | | | | |
|--|-------------------------------|---|-------------------------------------|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | | | c. LENGTH OF STAY IN 1b Thurmont | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hosp. | | | | d. STREET ADDRESS Route #1 | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) Ronald Frederick Cleveland Fritz Jr. | | | | 4. DATE OF DEATH Month December Day 28 Year 1956 | | | |
| 5. SEX Male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH December 28 | 9. AGE (In years last birthday) 14 | IF UNDER 1 YEAR Months 14 Days 10 | IF UNDER 24 HRS | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? United States |
| 13. FATHER'S NAME Ronald Cleveland Fritz | | | | 14. MOTHER'S MAIDEN NAME Patricia Ann Misner | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | 17. INFORMANT mother | | Address Thurmont, Route 1 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity DUE TO 776x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a m. _____ p m. _____ 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that I attended the deceased from 28 Dec 1956, to 28 Dec 1956, that I last saw the deceased alive on 28 Dec 1956, and that death occurred at 8:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 28 Dec 56 | | | | | | | |
| ACTUAL SIGNATURE A. M. Powell Jr. M.D. | | | | FREDERICK MD | | | |
| PHYSICIAN'S NAME (Type) A. M. Powell Jr. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Dec. 30. 1956 | | 22c. NAME OF CEMETERY OR CREMATORY Blue Ridge Cem. | | 22d. LOCATION (City, town, or county) Thurmont Fredk. Co MD (State) _____ | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. M. G. ... ADDRESS Thurmont, MD | | | | 24a. REC'D BY REGISTRAR DATE 31 Dec 1956 | | 24b. REGISTRAR'S SIGNATURE E. G. ... | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 3 1957

RECEIVED

12490

CERTIFICATE OF DEATH

Reg. Dist. No. 131

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Braddock Heights | | c. LENGTH OF STAY IN 1b 24 years | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Vindobona Convalescent & Rest Home | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) First ANNA Middle MAY Last GOSNELL | | 4. DATE OF DEATH Month December Day 4 Year 1956 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12 May 1890 |
| 9. AGE (In years last birthday) yrs 66 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hostess | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hostess | | 10b. KIND OF BUSINESS OR INDUSTRY Guest Cottage | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Jesse Anderson | | 14. MOTHER'S MAIDEN NAME Cornelia Everhart | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 213-18-8216 | |
| 17. INFORMANT Mrs. Charlotte G. Harrison, Martinsburg, W. Va. | | Address 129 E. John St., | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) Hypertensive Cardiovascular Disease DUE TO (c) Arteriosclerotic Heart Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| INTERVAL BETWEEN ONSET AND DEATH 1 Day 3 years 1 year | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 11-24 , 19 57 , to 12-4 , 19 56 , that I last saw the deceased alive on 12-4 , 19 56 , and that death occurred at 6:20 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4 W. 3rd St., Frederick, Md. DATE SIGNED 12/5/56 ACTUAL SIGNATURE Thomas E. Stone PHYSICIAN'S NAME (Type) Thomas E. Stone, M. D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 7 Dec 1956 | |
| 22c. NAME OF CEMETERY OR CREMATORY Park Heights Cemetery | | 22d. LOCATION (City, town, or county) (State) Brunswick, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland | | 24a. REC'D BY REGISTRAR 6 Dec 1956 | |
| 24b. REGISTRAR'S SIGNATURE Elizabeth L. Hatcher | | | |

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal in any event within 72 hours after death.

REPAIRED

1956

REPAIRED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12458

Reg. Dist. No. 145

12491

| | | | | | | | |
|--|---|---|--|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Indiana b. COUNTY Lawrence | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Myersville -rural | | | | c. LENGTH OF STAY IN TB 2 days | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rural | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Vint Edward S. Haley | | | | 4. DATE OF DEATH Month December Day 25 Year 19 56 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 27, 1904 | 9. AGE (In years last birthday) 55 yrs. | IF UNDER 1 YEAR Months 5 Days 5 | IF UNDER 24 HRS. Hours 5 Min. 5 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stone cutter | | 10b. KIND OF BUSINESS OR INDUSTRY Quarry | | 11. BIRTHPLACE (State or foreign country) Washington Co. Ind. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Grant Haley | | | | 14. MOTHER'S MAIDEN NAME Minnie Whittet | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 307-10-0264 | | 17. INFORMANT Address Bedford, Ind. Mrs Dorothy Haley, 612 N.P. St. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Phlebo-Thrombosis left femoral DUE TO (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH 45 minutes | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour 19 a. m. 19 p. m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) Bedford | | (County) Lawrence Co. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE B.O. Thomas | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) B.O. Thomas | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> December 25, 1956 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 22b. DATE THEREOF Dec. 26, 1956 | 22c. NAME OF CEMETERY OR CREMATORY Green Hill | | 22d. LOCATION (City, town, or county) Bedford, Lawrence Co. Ind. | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Paul F. Bittle | | | | 24a. REC'D BY REGISTRAR 12-26-56 | | 24b. REGISTRAR'S SIGNATURE Paul F. Bittle | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

BUREAU V. S.

DEC 17 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12459

Reg. Dist. No. 131

12458

| | | | |
|--|------------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | 2. USUAL RESIDENCE (Where deceased lived If Institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-RD#2 | |
| c. LENGTH OF STAY IN 1b About 20 Minutes | | d. STREET ADDRESS Near Urbana | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick, Memorial Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last ELEANOR LOUISE HARRIS | | 4. DATE OF DEATH Month Day Year December 20, 1956 | |
| 5. SEX Female | 6. COLOR OR RACE Colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1 Oct 1956 |
| 9. AGE (In years last birthday) yrs. 2 Months 19 Days 19 Hours 19 Min. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant | | 10b. KIND OF BUSINESS OR INDUSTRY Maryland | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Daniel W. Harris | | 14. MOTHER'S MAIDEN NAME Agnes Snowden | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Daniel W. Harris (Same as item #2) | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Vaccines pneumonia 470X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 days? | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE B O Thomas | | M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) B. O. Thomas, M. D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED 22 Dec 1956 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 22 Dec 1956 | |
| 22c. NAME OF CEMETERY OR CREMATORY Bartonsville Cemetery | | 22d. LOCATION (City, town, or county) (State) Frederick County Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland | | 24a. REC'D BY REGISTRAR DATE 22 Dec 1956 | |
| 24b. REGISTRAR'S SIGNATURE Elizabeth G. Hech | | | |

2069223XV3

BUREAU V. S.

1936

EC

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12469

CERTIFICATE OF DEATH

12460

Reg. Dist. No. 131

| | | | | | | | |
|--|----------------------------------|--|---|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | | | c. LENGTH OF STAY IN lb 4 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Three Pines Nursing Home | | | | d. STREET ADDRESS | | | |
| 3. NAME OF DECEASED (Type or print) First HENRY Middle AUGUST Last HERWIG | | | | 4. DATE OF DEATH Month December Day 28 Year 1956 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH November 1, 1870 | | 9. AGE (In years last birthday) 86 yrs | IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Candy Maker | | 10b. KIND OF BUSINESS OR INDUSTRY Confectionery | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Henry August Herwig | | | | 14. MOTHER'S MAIDEN NAME Katharina Woerner | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Address Mrs. Elmer E. Hodges - McKaig, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 14x Smility DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 yr. | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 7-1- , 19 55 , to 12-28- , 19 56 , that I last saw the deceased alive on 12-22- , 19 56 , and that death occurred at 7:00 P.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Rex R. Martin M.D. 35 E. Church Frederick Md | | | | DATE SIGNED 12-29-56 | | | |
| PHYSICIAN'S NAME (Type) Dr. Rex Martin | | | | 35 E. Church Street - Frederick, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Dec. 31, 1956 | | 22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery | | 22d. LOCATION (City, town, or county) (State) Frederick, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. C. E. Cline & Son - Frederick - Md. ADDRESS | | | | 24a. REC'D BY REGISTRAR DATE 31 Dec. 1956 | | 24b. REGISTRAR'S SIGNATURE Elmer E. Hodges | |

DEPT. OF A. S.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12461

12492

CERTIFICATE OF DEATH

Reg. Dist. No. 139

| | | | | | | | |
|---|----------------------------------|---|---|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cullen | | | | c. LENGTH OF STAY IN 1b 2397 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Victor Cullen State Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Earl Middle Edison Last Hill | | | | 4. DATE OF DEATH Month December Day 17 Year 1956 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH November 1, 1892 | 9. AGE (In years last birthday) yrs 64 | 10. IF UNDER 1 YEAR Months 6 Days 17 Hours 15 Min 00 | 11. IF UNDER 24 HRS Months 6 Days 17 Hours 15 Min 00 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocery | | 10b. KIND OF BUSINESS OR INDUSTRY Grocery | | 11. BIRTHPLACE (State or foreign country) White Hall, Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME David E. Hill | | | | 14. MOTHER'S MAIDEN NAME Ida Miller | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO 214-09-4770 | | 17. INFORMANT Deceased | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of rectum 4X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. OR 2X DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Tuberculosis - 7 1/2 years. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 9 months |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 26 , 19 50 , to December 17 , 19 56 , that I last saw the deceased alive on November 17 , 19 56 , and that death occurred at 3:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cullen, Maryland DATE SIGNED December 17, 1956 | | | | | | | |
| ACTUAL SIGNATURE <i>I. B. Lyon</i> | | M.D. Cullen, Maryland December 17, 1956 | | | | | |
| PHYSICIAN'S NAME (Type) I. B. Lyon, M.D. | | | | | | | |
| 22a. BURIAL, CREMATION, REINTERMENT (Specify) Burial | | 22b. DATE THEREOF 12-19-1956 | | 22c. NAME OF CEMETERY OR CREMATORY Rest Haven | | 22d. LOCATION (City, town, or county) (State) Hagerstown, Wash. D. C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Paul J. Bitts</i> | | ADDRESS <i>Myersville, Md.</i> | | 24a. REC'D BY REGISTRAR DATE 12/17/56 | | 24b. REGISTRAR'S SIGNATURE <i>I. B. Lyon</i> | |

RECEIVED

DEC 19 1956

BUREAU W. I.

12493

CERTIFICATE OF DEATH

12462

Reg. Dist. No. 131

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <i>Frederick</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Fred.</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Middletown</i> | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) First <i>Charles</i> Middle <i>R.</i> Last <i>Holter</i> | | 4. DATE OF DEATH Month <i>12</i> Day <i>28</i> Year <i>1956</i> | |
| 5. SEX <i>male</i> | 6. COLOR OR RACE <i>white</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>12-8-1870</i> |
| 9. AGE (In years last birthday) <i>86</i> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>farm owner</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>farm</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i> | |
| 13. FATHER'S NAME <i>William Holter</i> | | 14. MOTHER'S MAIDEN NAME <i>Elizabeth Cokenty</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i> | | 16. SOCIAL SECURITY NO. <i>none</i> | |
| 17. INFORMANT <i>Mrs. Lucius Holter</i> | | Address <i>Middletown, Md.</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> DUE TO (b) <i>Arterio-sclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <i>19</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>March, 1956</i> , to <i>Dec 28, 1956</i> , that I last saw the deceased alive on <i>Dec 20, 1956</i> , and that death occurred at <i>4:30 PM</i> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Elmer Harp</i> | | M.D. <i>Middletown</i> DATE SIGNED <i>12-29-56</i> | |
| PHYSICIAN'S NAME (Type) <i>Dr. J Elmer Harp</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i> | 22b. DATE THEREOF <i>12-31-1956</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>Reformed Cemetery</i> | 22d. LOCATION (City, town, or county) (State) <i>Middletown Md.</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Elmer Lill Co.</i> | | ADDRESS <i>Middletown Md.</i> | |
| 24a. REC'D BY REGISTRAR <i>DATE 2 Jan 1957</i> | | 24b. REGISTRAR'S SIGNATURE <i>Elizabeth G. Heck</i> | |

MEDICAL CERTIFICATION

TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. T.

JAN 3 1957

RECEIVED

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relayed to the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12494

CERTIFICATE OF DEATH

12463

Reg. Dist. No.

38

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY FREDERICK MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MASS b. COUNTY BOSTON | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Itascaville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BOSTON | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Riggs Hospital | | d. STREET ADDRESS 90 GAINSBOROUGH ST | |
| 3. NAME OF DECEASED (Type or print) Marian P. Horne | | 4. DATE OF DEATH December 25 1956 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec 15 1901 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 9. AGE (In years last birthday) 55 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS | |
| 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Lawrence Mass | |
| 13. FATHER'S NAME John Horne | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) | | 14. MOTHER'S MAIDEN NAME Evelyn M. Halper | |
| 16. SOCIAL SECURITY NO. — | | 17. INFORMANT Mrs. John Horne Address 90 GAINSBOROUGH ST BOSTON MASS | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Disease 4 d. d. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH 1 year |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. — 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from Oct 1 1953 , to Dec 25 1956 that I last saw the deceased alive on Dec 25 1956 , and that death occurred at 9:30 M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Joseph Lerner | | DATE SIGNED Dec 25 56 | |
| PHYSICIAN'S NAME (Type) Joseph Lerner M.D. | | ADDRESS (Street, city or town, state) Gammille | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF Dec 27-56 | 22c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEM | 22d. LOCATION (City, town, or county) (State) BLANDENSBURG M.D. |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. E. Falconer | | 24a. REC'D BY REGISTRAR DATE DEC 27-56 | |
| ADDRESS New Market Vg | | 24b. REGISTRAR'S SIGNATURE Lucian K. Falconer | |

U.S. BUREAU

JAN 7 1951

RECEIVED

12470

CERTIFICATE OF DEATH

Reg. Dist. No. 131

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY FREDERICK MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK | | c. LENGTH OF STAY IN 1b 4 DAYS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FREDERICK MEMORIAL HOSPITAL | | e. STREET ADDRESS R.F.D. Monrovia | |
| 3. NAME OF DECEASED (Type or print) First William E. Middle Johnson Last Johnson | | 4. DATE OF DEATH Month Dec Day 30 Year 1956 | |
| 5. SEX Male | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9-24-1902 |
| 9. AGE (In years last birthday) 54 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER | | 10b. KIND OF BUSINESS OR INDUSTRY Own Farm | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME MR. JAMES W. JOHNSON | | 14. MOTHER'S MAIDEN NAME EMMA BURDETTE | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 17. INFORMANT Mrs Gertrude Johnson, Monrovia, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260X DUE TO (b) Congestive Heart Failure DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 6 mo | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus and Subacute Nephritis (chronic) | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Dec 25, 1956 to Dec 30, 1956 that I last saw the deceased alive on Dec 30, 1956 , and that death occurred at 12:40 PM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE A. Austin Pearre M.D. | | ADDRESS (Street, city, town, state) Frederick, Md. DATE SIGNED 12/30/56 | |
| PHYSICIAN'S NAME (Type) A. Austin Pearre | | | |
| 22a. BURIAL, CREMATION, REMAINS (Specify) Burial | 22b. DATE THEREOF Jan. 2, 1957 | 22c. NAME OF CEMETERY OR CREMATORY Parklawn | 22d. LOCATION (City, town, or county) (State) Nr. Rockville, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm L. Mohamuth | | ADDRESS Damascus, Md. | |
| 24a. REC'D BY REGISTRAR DATE 3 Jan 1957 | | 24b. REGISTRAR'S SIGNATURE Elizabeth G. Hecker | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BULL 1 2

RECEIVED

CERTIFICATE OF DEATH

12465

12495

Reg. Dist. No.

| | | | | | | | |
|--|-----------------------------|--|-------------------------------------|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY FREDERICK MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY FREDERICK | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LIBERTYTOWN RURAL | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LIBERTYTOWN RURAL | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION UNION BRIDGE ROUTE 2 | | | | d. STREET ADDRESS UNION BRIDGE ROUTE 2 | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last EMMA E JONES | | | | 4. DATE OF DEATH Month Day Year DEC 28 1956 | | | |
| 5. SEX F | 6. COLOR OR RACE COL | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH DEC 21-1910 | | 9. AGE (In years last birthday) 46 yrs | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY OWN HOME | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME THOMAS E FISHER | | | | 14. MOTHER'S MAIDEN NAME MARTHA COATS | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. 215-20-9621 | | 17. INFORMANT Address CHESTER FISHER UNION BRIDGE MD | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bilateral DUE TO (c) Bilateral | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 yr. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Dec 1, 1954 , to 12/28, 1956 , that I last saw the deceased alive on 12/28, 1956 , and that death occurred at 5:55 PM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE M. C. Robertson M.D. | | | | ADDRESS (Street, city or town, state) NEW WINDSOR, MD DATE SIGNED 12/28/56 | | | |
| PHYSICIAN'S NAME (Type) M E ROBERTSON | | | | NEW WINDSOR MD | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 12/31/56 | | 22c. NAME OF CEMETERY OR CREMATORY OLDFIELDS | | 22d. LOCATION (City, town, or county) (State) FREDERICK CO MD | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS D D Hartzler & Sons, New Windsor, Md | | | | 24a. REC'D BY REGISTRAR DATE AN 2 11 | | 24b. REGISTRAR'S SIGNATURE | |

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RECEIVED

12496

CERTIFICATE OF DEATH

12466

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1 PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND | | | | 2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Frederick</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Myersville</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Myersville</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Ira</u> Middle <u>Walter</u> Last <u>Leatherman</u> | | | | 4. DATE OF DEATH Month <u>12</u> Day <u>4</u> Year <u>1956</u> | | | |
| 5. SEX <u>male</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>6/11/1892</u> | |
| 9. AGE (In years last birthday) <u>64</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farm owner, ret.</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 13. FATHER'S NAME <u>Alfred J. Leatherman</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Clara F. Leatherman</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>none</u> | | 17. INFORMANT <u>Mrs. Sadie Leatherman, Myersville, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>18 mo</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from <u>July</u> , 19 <u>55</u> , to <u>Dec 4</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 3</u> , 19 <u>56</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>J. Elmer Harp</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>Middletown</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Dr. J. Elmer Harp</u> | | | | DATE SIGNED <u>12-5-56</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>12/7/1956</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Grossnickle Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Frederick Co., Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Gladhill Co., Middletown, Md.</u> | | | | 24a. REC'D BY REGISTRAR <u>DATE 12-6-1956</u> | | 24b. REGISTRAR'S SIGNATURE <u>Shoy M. Bittle</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3 A CRYSTAL

1944

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12467

Reg. Dist. No.

141

12483

| | | | | | | | |
|---|----------------------------------|---|--------------------------------------|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick | | c. LENGTH OF STAY IN 1b 40 years | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 21 North Virginia Avenue | | | | d. STREET ADDRESS 613 Brunswick Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Daisy Middle Loretta Last Leopold | | | | 4. DATE OF DEATH Month 12 Day 27 Year 1955 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7-10-1970 | | 9. AGE (In years and months) 77 yrs. | IF UNDER 1 YEAR Months 7 Days 17 | IF UNDER 24 HRS. Hours 19 Min. 55 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Charles A. Lewis | | | | 14. MOTHER'S MAIDEN NAME Annie M. Cline | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. No | | 17. INFORMANT Address Mrs. Margaret C. Ayers, Brunswick, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO 0.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO _____ INTERVAL BETWEEN ONSET AND DEATH 3 minutes | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE B. O. Thomas | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type) B. O. Thomas | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 12-30-1956 | | 22c. NAME OF CEMETERY OR CREMATORY Reformed | | 22d. LOCATION (City, town, or county) (State) Knoxville Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE B. O. Thomas | | | | ADDRESS Brunswick, Maryland | | 24a. REC'D BY REGISTRAR 12-27-1955 | |
| | | | | 24b. REGISTRAR'S SIGNATURE L. E. Burke | | | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V S

JAN 7 1957

RECEIVED

12497

CERTIFICATE OF DEATH

Reg. Dist. No. 131

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Frederick</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middletown</u> c. LENGTH OF STAY IN 1b <u>life</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middletown</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Edna K. Lighter</u> | | | | 4. DATE OF DEATH Month Day Year <u>12 14 1956</u> | | | |
| 5. SEX <u>female</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>1/30/1881</u> | |
| 9. AGE (In years last birthday) <u>75</u> yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>schoolteacher</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>school</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | | | 13. FATHER'S NAME <u>Daniel Lighter</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Mary Margaret Vananda</u> | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> | | | |
| 16. SOCIAL SECURITY NO. <u>none</u> | | | | 17. INFORMANT <u>Miss Carlotta Hayes, Braddock, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Arterio Sclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 21. I certify that I attended the deceased from <u>June, 1953</u> , to <u>Dec 14, 1956</u> , that I last saw the deceased alive on <u>Dec 14, 1956</u> , and that death occurred at <u>2:10 P.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>J Elmer Harp</u> M.D. | | | | ADDRESS (Street, city or town, state) DATE SIGNED <u>Middletown Md. 12-15-56</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Dr. J. Elmer Harp</u> | | | | <u>Middletown Md.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>12/16/1956</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Reformed Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Middletown Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Gladhill Co., Middletown, Md.</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>19 Dec 1956</u> | | 24b. REGISTRAR'S SIGNATURE <u>Elizabeth S. Heck</u> | |

TO HOSPITAL ATTENDING PHYSICIAN: The form requires that the death certificate be completed within 4 hours after death. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.

1956

RECEIVED

12498

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|----------------------------------|--|---|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosemont | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosemont | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS | | | |
| 3. NAME OF DECEASED (Type or print) First Andrew Middle Cleveland Last Lowery | | | | 4. DATE OF DEATH Month 12 Day 5 Year 1956 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6-28-1892 | | 9. AGE (In years last birthday) yrs. 64 | IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Track Foreman | | | 10b. KIND OF BUSINESS OR INDUSTRY B. & O. R.R. Co | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME George Lowery | | | | 14. MOTHER'S MAIDEN NAME Laura J. Poomroy | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) World I 706-07-7707 | | 17. INFORMANT Address Mrs. Sadie Lowery, Knoxville, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 784.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 10 min. |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 12-5-1956 to 12-5-1956 , that I last saw the deceased alive on 12-5-1956 , and that death occurred at 6:15 PM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE C. E. Pruitt | | | | ADDRESS (Street, city or town, state) DATE SIGNED Brunswick, Maryland 12-6-56 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 12-7-1956 | | 22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet | | 22d. LOCATION (City, town, or county) (State) Frederick, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE B. R. Felt | | | | ADDRESS Brunswick, Maryland | | 24a. REC'D BY REGISTRAR DATE 12-11-56 | |
| | | | | 24b. REGISTRAR'S SIGNATURE <i>Virginia Barker</i> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 5 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 5 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3 A 111111

111111

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12499

CERTIFICATE OF DEATH

12470

Reg. Dist. No. 131

| | | | | | | | |
|---|------------------------------|---|--|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Woodstock</u> | | | | c. LENGTH OF STAY IN 1b <u>25 yrs</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS <u>Rural - Woodstock</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>LAWRENCE CASPER MEHRLING</u> | | | | 4. DATE OF DEATH Month <u>Dec.</u> Day <u>21</u> Year <u>1956</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept. 1, 1897</u> | | 9. AGE (In years last birthday) <u>59</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Or-Libre Bush Co.</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | 13. FATHER'S NAME <u>Casper Mehrling</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Betty Eyles</u> | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | | |
| 16. SOCIAL SECURITY NO. <u>214-10-3501</u> | | | | 17. INFORMANT <u>Mrs. Marlin Skinner, Woodstock</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Arteriosclerosis</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 20g. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>Mr.</u> , 19 <u>56</u> to <u>Dec 21</u> , 19 <u>56</u> that I last saw the deceased alive on <u>Dec 20</u> , 19 <u>56</u> , and that death occurred at <u>10</u> M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>J. H. Missin</u> M.D. | | | | DATE SIGNED <u>Dec 21</u> | | | |
| PHYSICIAN'S NAME (Type) <u>J. H. Missin</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>12/24/56</u> | | <u>Rocky Hill Cemetery</u> | | <u>W. Woodstock Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. C. Barton</u> | | | | ADDRESS <u>Walkersville, Md.</u> | | 24a. REC'D BY REGISTRAR DATE <u>24 Dec 1956</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Elizabeth S. Hecks</u> | | | |

BUREAU V. S.

EC 1036

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12471

CERTIFICATE OF DEATH

Reg. Dist. No. 12471

| | | | |
|--|-------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | |
| c. LENGTH OF STAY IN TB Lifetime | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 116 East 6th Street | | d. STREET ADDRESS 116 East 6th Street | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Dora Middle E. Last Morgan | | 4. DATE OF DEATH Month December Day 31 Year 56 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 27-1886 |
| 9. AGE (In years last birthday) 70 yrs. | | IF UNDER 1 YEAR: Months 70 Days 19 Hours 56 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress | | 10b. KIND OF BUSINESS OR INDUSTRY Tailoring Co. | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Harry Knipple | | 14. MOTHER'S MAIDEN NAME Mary Cramer | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 219-03-5543 | |
| 17. INFORMANT Mrs. John E. Staley-Hagerstown-Md. (daughter) | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Minutes | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 1946 to Dec 31, 1956 , that I last saw the deceased alive on Dec. 15, 1956 , and that death occurred at 3:00 M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Watkins Acres- Frederick-Md. DATE SIGNED 1/31/57 | | | |
| ACTUAL SIGNATURE B. Thomas | | M.D. Watkins Acres- Frederick-Md. | |
| PHYSICIAN'S NAME (Type) Dr. B.O. Thomas-Sr. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Jan. 3-1957 | |
| 22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery | | 22d. LOCATION (City, town, or county) (State) Frederick- Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE C. E. Clement & Son | | ADDRESS Frederick, Maryland | |
| 24a. REC'D BY REGISTRAR 2 Jan 1957 | | 24b. REGISTRAR'S SIGNATURE Elyzabeth B. Hark | |

RECEIVED

JAN 3. 1957

BUREAU Y. A.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12472

12500

CERTIFICATE OF DEATH

Reg. Dist. No. 131

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#4 | | | | c. LENGTH OF STAY IN 1b Years | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) Ballenger Creek Road | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#4 | | | |
| f. STREET ADDRESS Ballenger Creek Road | | | | g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First ELLIE Middle BERNICE Last MYERS | | | | 4. DATE OF DEATH Month December 1, Day 1956 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 19 Nov 1872 | |
| 9. AGE (In years last birthday) 84 yrs. | | IF UNDER 1 YEAR Months 84 Days 84 Hours 84 Min 84 | | IF UNDER 24 HRS Months 84 Days 84 Hours 84 Min 84 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME William Henry Howard | | 14. MOTHER'S MAIDEN NAME Ellen Rebecca Culler | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give, or unknown) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Mrs. George R. Bell (Same As Item #1) | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Congestive failure + uremia DUE TO 1 week Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Auricular fibrillation DUE TO 1 month (c) Arterio-sclerotic heart dis. 4 yrs. | | | | INTERVAL BETWEEN ONSET AND DEATH 1 week 1 month 4 yrs. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe Senile asthenia | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) Frederick, Md. | | | | 20g. (County) Frederick | | 20h. (State) Md. | |
| 21. I certify that I attended the deceased from 1948 to 1 DEC , 19 56 , that I last saw the deceased alive on 1 DEC , 19 56 , and that death occurred at 12:25 A M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Charles H. Conley, Jr. M.D. | | | | ADDRESS (Street, city or town, state) 228 N. Market St., Frederick, Md. | | | |
| PHYSICIAN'S NAME (Type) Charles H. Conley, Jr., M.D. | | | | DATE SIGNED 12/3/56 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 4 Dec 1956 | | 22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery | | 22d. LOCATION (City, town, or county) (State) Frederick, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland | | | | 24a. REC'D BY REGISTRAR 3 DEC 1956 | | 24b. REGISTRAR'S SIGNATURE Elizabeth G. Hach | |

BUREAU V. S.

EC 1070

RECEIVED

12501

CERTIFICATE OF DEATH

Reg. Dist. 12473

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WALKERSVILLE</u> | | | | c. LENGTH OF STAY IN 1b <u>2 YRS</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RURAL</u> | | | | e. STREET ADDRESS <u>RURAL</u> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>SARAH ELIZABETH OREM</u> | | | | 4. DATE OF DEATH Month Day Year <u>DEC. 26 1956</u> | | | |
| 5. SEX <u>FEMALE</u> | | 6. COLOR OR RACE <u>COLORED</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH <u>JAN. 3-1852</u> | |
| 9. AGE (In years last birthday) <u>104</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOMESTIC</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEKEEPER</u> | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | | | | | | |
| 13. FATHER'S NAME <u>FRANK DORSEY</u> | | | | 14. MOTHER'S MAIDEN NAME <u>HARRIETT P</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>NO</u> | | 17. INFORMANT Address <u>HARRY OREM - WALKERSVILLE, MD</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, Old Age</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>4X</u> DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>1945</u> , 19 <u>56</u> , to <u>1956</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 10</u> , 19 <u>56</u> , and that death occurred at <u>2:10 PM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Ea M. Beall</u> | | | | ADDRESS (Street, city or town, state) DATE SIGNED <u>Libertytown, Md. Dec. 26/56</u> | | | |
| PHYSICIAN'S NAME (Type) <u>IRA W. BEALL M.D.</u> | | | | <u>LIBERTYTOWN, MD.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| <u>BURIAL</u> | | <u>12/29/56</u> | | <u>WESLEY CEM.</u> | | <u>LIBERTYTOWN MD.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>DD Hutchins Sons, Libertytown, Md.</u> | | | | 24a. REC'D BY REGISTRAR <u>DATE 12-31-56</u> | | 24b. REGISTRAR'S SIGNATURE <u>E. J.</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A 1

DEC 31 1951

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12502

CERTIFICATE OF DEATH

Reg. Dist. No. 12474

| | | | |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MD b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont | | c. LENGTH OF STAY IN 1b 50 yrs | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First LILLIE Middle MAY Last POOLE | | 4. DATE OF DEATH Month Dec. Day 29th Year 1956 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 8. 1876 |
| 9. AGE (In years last birthday) yrs 80 | | IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 11. BIRTHPLACE (State or foreign country) Fredk. Co. MD | | 12. CITIZEN OF WHAT COUNTRY? U.S.A | |
| 13. FATHER'S NAME Frank I. Portner | | 14. MOTHER'S MAIDEN NAME Sophia Davis | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. No | |
| 17. INFORMANT Mrs Mary Stull Thurmont MD | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO 2322 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 4 wks 3 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of hip - old | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour 0 a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Dec. 1 - 1956 to Dec. 27, 1956 , that I last saw the deceased alive on Dec. 21, 1956 , and that death occurred at 8 A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE James K. Gray | | ADDRESS (Street, city or town, state) Thurmont - Md. | |
| PHYSICIAN'S NAME (Type) James K. Gray. Thurmont MD | | DATE SIGNED | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Dec 31. 1956 | |
| 22c. NAME OF CEMETERY OR CREMATORY Lewistown Cem. | | 22d. LOCATION (City, town, or county) (State) Lewistown Fredk. Co. Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Raymond G. G. G. G. | | ADDRESS Thurmont, MD | |
| 24a. REC'D BY REGISTRAR DATE 31 Dec 1956 | | 24b. REGISTRAR'S SIGNATURE Elizabeth B. Hark | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

14N 3 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12472

CERTIFICATE OF DEATH

12475
Reg. Dist. No. 13

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> | | | | c. LENGTH OF STAY IN 1b <u>1 da</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hosp.</u> | | | | d. STREET ADDRESS <u>Thurmont</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>NELLIE</u> First <u>MARGARET</u> Middle <u>P. Pryor</u> Last | | | | 4. DATE OF DEATH Month <u>Dec.</u> Day <u>1</u> Year <u>1956</u> | | | |
| 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Nov. 16. 1899</u> | |
| 9. AGE (In years last birthday) <u>57</u> yrs | | 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | 11. BIRTHPLACE (State or foreign country) <u>Thurmont</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | |
| 10a. USAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Thurmont</u> | |
| 13. FATHER'S NAME <u>Joseph E. Wilhide</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Lillie M. Freeze</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>No</u> | | 17. INFORMANT <u>Wm. S. Pryor Sr.</u> Address <u>Thurmont. MD</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Infection of brain</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cocclusion of left Cerebral artery due to embolus</u> DUE TO (c) <u>Chronic heart disease with mural thrombus in right and left auricular appendages</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 days</u> <u>3 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>thrombus in right and left auricular appendages</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>11/29</u> , 19 <u>56</u> , to <u>12/1</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12/1</u> , 19 <u>56</u> , and that death occurred at <u>11:30 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4 E. Church St</u> DATE SIGNED <u>12/1/56</u> ACTUAL SIGNATURE <u>Henry V. Chase</u> M.D. PHYSICIAN'S NAME (Type) <u>Henry V. Chase</u> <u>Frederick Maryland</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Dec. 3. 1956</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>United Brethern Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Thurmont. Fredk Co MD</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond B. ...</u> ADDRESS <u>Thurmont MD</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>5 Dec. 1956</u> | | 24b. REGISTRAR'S SIGNATURE <u>Elizabeth S. Heck</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. E.

DEC 6

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed in 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12476

CERTIFICATE OF DEATH

12503

Reg. Dist. No. 81

| | | | | | | | |
|---|---|--|--------------------------------------|---|--------------------------------|--|--|
| 1. PLACE OF DEATH COUNTY <u>Frederick</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Union Bridge</u> LENGTH OF STAY (In this place) <u>Life</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Frederick</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Union Bridge</u> STREET ADDRESS <u>Rd.</u> (If rural give location) | | | |
| 3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Fannie</u> <u>Diehl</u> <u>Repp</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>12</u> - <u>3</u> - <u>1956</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>2-19-1868</u> | 9. AGE last birthday <u>88</u> yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Frederick Co. Md</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | |
| 13. FATHER'S NAME <u>John H. Diehl</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Hannah Forty</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT'S ADDRESS <u>John S. Repp</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u> | | | | | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio Sclerosis</u> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | | 21f. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <u>Jan 4</u> , 19 <u>56</u> , to <u>Dec 3</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12-3-</u> , 19 <u>56</u> , and that death occurred at <u>2:30</u> P.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>J. N. Legg</u> | | M.D. | | ADDRESS (Street, city, town, state) <u>Union Bridge Md</u> | | DATE SIGNED <u>12-4-56</u> | |
| 23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | DATE THEREOF <u>12-5-56</u> | NAME OF CEMETERY OR CREMATORY <u>Beaver Dam</u> | | LOCATION (City, town, or county) (State) <u>Union Bridge Md</u> | | | |
| 24. REC'D BY REGISTRAR <u>12/4/56</u> | REGISTRAR'S SIGNATURE <u>[Signature]</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond K. Wright</u> | | ADDRESS | | | |

RECEIVED

DEC 11 1956

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12473 FilmG209 1-17-56
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12473
CERTIFICATE OF DEATH

12477
131

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | | | c. LENGTH OF STAY IN 1b Years | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) Frederick Memorial Hospital | | | | d. STREET ADDRESS 120 East Eighth Street | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First JESSE Middle JAMES Last RIPPEON | | | | 4. DATE OF DEATH Month December Day 22 Year 19 56 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 18 May 1884 | 9. AGE (In years last birthday) 72 yrs. | IF UNDER 1 YEAR Months Days Hours Min | IF UNDER 24 HRS Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Supt. | | | | 10b. KIND OF BUSINESS OR INDUSTRY Country Club | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME Zacharias Rippeon | | | | 14. MOTHER'S MAIDEN NAME Mary Wilson | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No | | | | 16. SOCIAL SECURITY NO 577-26-8013 | | 17. INFORMANT Mrs. Carrie Crum Rippeon Address (Same as item #2) | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arterio sclerosis DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 5 days 5 yrs + | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from Dec. 22, 1956 to Dec. 22, 1956 , that I last saw the deceased alive on Dec. 22, 1956 , and that death occurred at 10 P. M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE B. O. Thomas M.D. | | | | ADDRESS (Street, city or town, state) 228 N. Market St., Frederick, Md. | | | |
| DATE SIGNED 12/24/56 | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | | | |
| 22b. DATE THEREOF 26 Dec 1956 | | 22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery | | 22d. LOCATION (City, town, or county) Frederick, Maryland | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland | | | | 24a. REC'D BY REGISTRAR DATE 26 Dec 1956 | | 24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck | |

BUREAU V. S.

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12504

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Mt. Airy</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Mt Airy</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home - Rt 1 - Mt. Airy</u> | | e. STREET ADDRESS <u>Route 1-</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Ezra</u> Last <u>Routzohn</u> | | 4. DATE OF DEATH Month <u>December</u> Day <u>15</u> Year <u>1956</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Dec. 5, 1900</u> |
| 9. AGE (In years last birthday) <u>56</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Enos Sasser Routzohn</u> | | 14. MOTHER'S MAIDEN NAME <u>Alice Biser</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>216-05-9813</u> | |
| 17. INFORMANT <u>Mrs. George E. Routzohn - Mt Airy</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Thrombosis, Hemiparesis,</u> DUE TO <u>Invalidism</u> (c) | | | INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>3 years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>Dec. 29, 1953</u> , to <u>Dec. 15, 1956</u> , that I last saw the deceased alive on <u>June 15, 1956</u> , and that death occurred at <u>8:30 P.M.</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>W.B. Culwell</u> | | ADDRESS (Street, city or town, state) <u>Mt. Airy, Md.</u> DATE SIGNED <u>12/15/56</u> | |
| PHYSICIAN'S NAME (Type) <u>W.B. Culwell</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>12/18/1956</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>E.H.B. Cem. Pleasant Walk</u> | 22d. LOCATION (City, town, or county) (State) <u>Frederick Co. Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Gladhill Co. Middletown, Md.</u> | | 24a. REC'D BY REGISTRAR DATE <u>12-18-56</u> | |
| | | 24b. REGISTRAR'S SIGNATURE <u>Lucian K. Falconer</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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JAN 7 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12479

12505

CERTIFICATE OF DEATH

Reg. Dist. No. 131

| | | | | | | | |
|--|------------------------------------|---|------------------------------------|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adamstown-Rural RD#1 | | | | c. LENGTH OF STAY IN 1b 31 years | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Near Adamstown | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First OTHO Middle SCOTT Last SCOTT | | | | 4. DATE OF DEATH Month December Day 1 Year 1956 | | | |
| 5. SEX Male | 6. COLOR OR RACE Colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Unknown | 9. AGE (In years last birthday) 58 yn | | IF UNDER 1 YEAR Months 5 Days 1 Hours 19 Min 56 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Farm | | 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME William Scott | | | | 14. MOTHER'S MAIDEN NAME Martha Timbers | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO 217-305-519 | | 17. INFORMANT Ralph F. Scott, 3730 N. 18th St., Philadelphia 40, Pa. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO (b) Hypertensive Cardiovascular disease DUE TO (c) ? Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | INTERVAL BETWEEN ONSET AND DEATH 12 hrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocarditis | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 11/24, 1956 , to 12/1, 1956 , that I last saw the deceased alive on 11/24, 1956 , and that death occurred at 8 A M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Jefferson, Maryland DATE SIGNED 3 Dec 1956 | | | | | | | |
| ACTUAL SIGNATURE A. Talbott Brice M.D. | | | | PHYSICIAN'S NAME (Type) A. Talbott Brice, M. D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 4 Dec 1956 | | 22c. NAME OF CEMETERY OR CREMATORY Sunnyside Methodist Cem. | | 22d. LOCATION (City, town, or county) (State) Frederick County Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland | | | | 24a. REC'D BY REGISTRAR 4 Dec 1956 | | 24b. REGISTRAR'S SIGNATURE Elizabeth S. Heck | |

BUREAU V. S.

DEC 6 1956

RECEIVED

12506

CERTIFICATE OF DEATH

12480

Reg. Dist. No. 138

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL FREDERICK</u> | | | | c. LENGTH OF STAY IN 1b <u>4 HOURS</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW MARKET</u> | | | |
| | | | | d. STREET ADDRESS | | | |
| | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>HOWARD BERNARD SELBY</u> | | | | 4. DATE OF DEATH Month Day Year <u>December 10 1956</u> | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>FEB 2 - 1896</u> | |
| | | | | 9. AGE (In years last birthday) <u>60</u> yrs | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STATION ATTENDANT</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>GASOLINE</u> | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | |
| | | | | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>HOWARD C. SELBY</u> | | | | 14. MOTHER'S MAIDEN NAME <u>MARY C. HOBBS</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WORLD WAR I</u> | | | | 16. SOCIAL SECURITY NO. <u>216-30-3712</u> | | 17. INFORMANT <u>MRS ANN SELBY (WIFE) NEW MARKET MD</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 1-18-1919 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myocarditis -</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH <u>Immediate more than 2 years</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from <u>AUGUST</u> 19 <u>55</u> , to <u>NOV.</u> 19 <u>56</u> , that I last saw the deceased alive on <u>Nov. 1</u> 19 <u>56</u> , and that death occurred at <u>2:00 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Mt. Airy, Maryland</u> DATE SIGNED <u>12/11/56</u> | | | | | | | |
| ACTUAL SIGNATURE <u>W.B. Culwell</u> M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>DEC-13-1956</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>MOUNT OLIVET CEM</u> | | 22d. LOCATION (City, town, or county) (State) <u>FREDERICK MD</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W.E. Falconer</u> | | | | ADDRESS <u>New Market Md</u> | | 24a. REC'D BY REGISTRAR <u>DATE Dec 12-56</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Lillian K. Falconer</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 17 1956

RECEIVED

12471

CERTIFICATE OF DEATH

Reg. Dist. No. 131

| | | | | | | | |
|--|----------------------------------|---|---|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | c. LENGTH OF STAY IN 1b Lifetime | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) Frederick Memorial Hospital | | | | d. STREET ADDRESS 326 East Patrick Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First CHARLES Middle WILLIAM Last SHAW | | | | 4. DATE OF DEATH Month December Day 2 Year 19 56 | | | |
| 5 SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH October 14, 1883 | | 9. AGE (In years last birthday) 73 yrs. | | IF UNDER 1 YEAR Months Days Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dyer | | 10b. KIND OF BUSINESS OR INDUSTRY Hosiery | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Samuel Shaw | | | | 14. MOTHER'S MAIDEN NAME Alice Null | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 214-10-1138A | | 17. INFORMANT Mrs. Charles W. Shaw - 326 E. Patrick Street | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Thrombosis (c) Arteriosclerotic Heart Disease | | | | | | INTERVAL BETWEEN ONSET AND DEATH 16 Days 11 Days 3 months | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June 1, 1954 , to Dec 2, 1957 , that I lost saw the deceased olive on Dec 2, 1957 , and that death occurred at 5:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4 West Third Street- Frederick-Md. DATE SIGNED 12-4-57 | | | | | | | |
| ACTUAL SIGNATURE Thomas E. Stone M.D. | | | | PHYSICIAN'S NAME (Type) Dr. Thomas E. Stone | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Dec. 5, 1956 | | 22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery | | 22d. LOCATION (City, town, or county) (State) Frederick, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE C. E. Clinet Son - ADDRESS Frederick Md. | | | | 24a. REC'D BY REGISTRAR DATE 4 Dec 1956 | | 24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 6 1956

RECEIVED

12475

CERTIFICATE OF DEATH

Reg. Dist. No. 131

| | | | | | | | |
|--|----------------------------------|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | | |
| c. LENGTH OF STAY IN life Life | | | | d. STREET ADDRESS 227 Washington Street | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last GEORGE WILLIAM SHIPLEY | | | | 4. DATE OF DEATH Month Day Year December 20, 1956 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH September 9, 1875 | 9. AGE (In years last birthday) yrs. 81 | IF UNDER 1 YEAR Months Days Hours Min | IF UNDER 24 HRS Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Partner | | 10b. KIND OF BUSINESS OR INDUSTRY Bottling Works | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME William H. Shipley | | | | 14. MOTHER'S MAIDEN NAME Mary E. Kettler | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No | | 16. SOCIAL SECURITY NO. 214-10-5604 | | 17. INFORMANT Address Mrs. Elizabeth M. Shipley, same as item 2 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 591x DUE TO Acute Congestive Cardiac acute pulmonary edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arterio sclerosis DUE TO parenchymatous nephritis (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 5/20/56 |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Dec. 19, 1956 to Dec. 20, 1956 , that I last saw the deceased alive on Dec. 19, 1956 , and that death occurred at 8:55 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Professional Bldg., Frederick, Md. DATE SIGNED 12/21/56 ACTUAL SIGNATURE B. O. Thomas M.D. Professional Bldg., Frederick, Md. PHYSICIAN'S NAME (Type) Dr. B. O. Thomas Sr. Same as above | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Dec. 24, 1956 | | 22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery | | 22d. LOCATION (City, town, or county) (State) Frederick, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS M. R. Etchison & Son, Frederick, Maryland | | | | 24a. REC'D BY REGISTRAR DATE 21 Dec. 1956 | | 24b. REGISTRAR'S SIGNATURE Elizabeth L. Hark | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. P.

1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|---------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived) II institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 27</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hosp.</u> | | d. STREET ADDRESS <u>3404 Hopkins Ave</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Harper</u> First <u>Joshua G</u> Middle <u>Shipley</u> Last <u>Shipley</u> | | 4. DATE OF DEATH Month <u>Dec</u> Day <u>26</u> Year <u>1956</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Apr 25 1880</u> |
| 9. AGE (In years last birthday) <u>76</u> yrs | | IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hot Watchman</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Howard Co Md</u> | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>Oliver Shipley</u> | | 14. MOTHER'S MAIDEN NAME <u>Margaret Shipley</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Norman Downing-811 Chapelgate Lane</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1 Anteroinfarctive Cardiovascular Disease</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2 Malnutrition</u> (b) <u>3 Burchpneumonia bilateral</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>12/16</u> , 19 <u>56</u> , to <u>12/26</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12/26</u> , 19 <u>56</u> , and that death occurred at <u>5:45 P.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Henry V. Chase</u> M.D. | | ADDRESS (Street, city or town, state) <u>4 E. Church St</u> | |
| PHYSICIAN'S NAME (Type) <u>Henry V. Chase</u> | | DATE SIGNED <u>12/26/56</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>12/29/56</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Glen Burnie Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook Sme-1217 St Paul St</u> | | ADDRESS <u>St Paul St</u> | |
| 24a. REC'D BY REGISTRAR <u>DEC 27 1956</u> | | 24b. REGISTRAR'S SIGNATURE <u>E. J. H. L.</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 1 1954

RECEIVED

12477

CERTIFICATE OF DEATH

Reg. Dist. No. 131

| | | | | | | | |
|--|---|---|---------------------------------|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Frederick</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> | | | | c. LENGTH OF STAY IN 1b <u>3 days</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u> | | | | d. STREET ADDRESS <u>117 A. Ry - Route 1</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Caroline</u> Middle <u>-</u> Last <u>Showns</u> | | | | 4. DATE OF DEATH Month <u>Dec.</u> Day <u>9</u> Year <u>1956</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1867</u> | 9. AGE (In years last birthday) <u>89</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u> | | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Mr. - STROOP</u> | | | | 14. MOTHER'S MAIDEN NAME <u>-</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>-</u> | | 17. INFORMANT <u>MRS. JAMES KING</u> Address <u>117 A. Ry Md.</u> (<u>DAUGHTER</u>) | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senility</u> DUE TO (c) <u>Arteriosclerotic heart disease</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>years</u> <u>1 yr</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | | |
| 21. I certify that I attended the deceased from <u>Dec. 6</u> , 19 <u>56</u> , to <u>Dec 9</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 8</u> , 19 <u>56</u> , and that death occurred at <u>6:15</u> M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Rex R Martin</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>35 E. Church Frederick Md</u> DATE SIGNED <u>12-9-56</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Rex R Martin</u> | | | | | | | |
| 22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>12-12-56</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Grove Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>M. Mt. Jackson - Va.</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>C. E. Cline & Son</u> ADDRESS <u>Frederick Md.</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>11 Dec. 1956</u> | 24b. REGISTRAR'S SIGNATURE <u>Elizabeth G. Herb</u> | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 1955

RECEIVED

12507

CERTIFICATE OF DEATH

Reg. Dist. No.

131

| | | | | | | | |
|---|-------------------------------|--|--------------------------------------|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Frederick</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> | | | | c. LENGTH OF STAY IN 1b <u>9 1/2</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Hospital</u> | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>May</u> Last <u>Thomas</u> | | | | 4. DATE OF DEATH Month <u>Dec</u> Day <u>28</u> Year <u>1956</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>MAY 30, 1864</u> | 9. AGE (In years last birthday) <u>92</u> yrs. | IF UNDER 1 YEAR: Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> | | IF UNDER 24 HRS: Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | | 11. BIRTHPLACE (State or foreign country) <u>Md</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>William D. Thomas</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary E. Gutter</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u></u> | | 17. INFORMANT <u>FAMILY RECORD</u> Address <u></u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> <u>years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u> | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u> | |
| | | | | 20f. (City or town) <u></u> (County) <u></u> (State) <u></u> | | | |
| 21. I certify that I attended the deceased from <u>1954</u> to <u>12/28</u> 1956, that I last saw the deceased alive on <u>12/20</u> 1956, and that death occurred at <u>9:40 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>James B. Thowen</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>228 N. Market St. Frederick, Md.</u> | | DATE SIGNED <u>12/27/56</u> | |
| PHYSICIAN'S NAME (Type) <u>James B. Thowen</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>12/28/56</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>St. Elizabeth's</u> | | 22d. LOCATION (City, town, or county) <u>Frederick</u> (State) <u>Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Elizabeta G. Heck</u> ADDRESS <u>Frederick Md</u> | | | | 24a. REC'D BY REGISTRAR <u>Elizabeta G. Heck</u> | | 24b. REGISTRAR'S SIGNATURE <u>Elizabeta G. Heck</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JAN 31 1961
BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12486

12478

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

131

| | | | | | | | |
|--|------------------------------|---|--|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick Memorial | | | | c. LENGTH OF STAY IN 1b Frederick, R.F.D 6 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital | | | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Richard Eugene Tourtellotte | | | | 4. DATE OF DEATH Month Day Year December 30 19 56 | | | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH June 15, 1916 | | 9. AGE (In years last birthday) 40 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Providence, R.I. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME George Albert Tourtellotte | | | | 14. MOTHER'S MAIDEN NAME Mary Hurley | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Beulah Louise Tourtellotte | | Address Frederick, Md R.F.D 6 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General peritonitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Perforated Doudenal ulcer DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 4 days ? 5 days ? | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE B.O. Thomas NAME (Type) B.O. Thomas | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| DATE SIGNED December 31, 1956 | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 22b. DATE THEREOF Jan. 1, 1957 | | 22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery | | 22d. LOCATION (City, town, or county) (State) Avon, Connecticut | |
| 23. FUNERAL DIRECTOR'S SIGNATURE C. C. Linehan LWS | | | | ADDRESS Frederick, Maryland | | 24a. REC'D BY REGISTRAR DATE 31 Dec 1956 | |
| | | | | 24b. REGISTRAR'S SIGNATURE E. G. L. B. H. H. H. | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Give Page 4 to the funeral director. Give Page 5 to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. B.

JAN 3 1957

RECEIVED

12508

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Fairfield, Pa. | | | | c. LENGTH OF STAY IN 1b 47 yrs, | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Fairfield, Pa. | | | | d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fairfield, RD.# 1 Pa. | | | |
| d. STREET ADDRESS Fairfield, Pa. R.D.#1 | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Cora Middle Adela Last Tressler | | | | 4. DATE OF DEATH Month December Day 23 Year 1956 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Sept, 3, 1872 | |
| 9. AGE (In years last birthday) yrs 84 | | IF UNDER 1 YEAR Months Days Hours Min. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 11. BIRTHPLACE (State or foreign country) Adams County, Pa. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY -- | | 11. BIRTHPLACE (State or foreign country) Adams County, Pa. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John Linebaugh | | | | 14. MOTHER'S MAIDEN NAME Sarah Ann Harshman | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio renal disease 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerosis DUE TO (c) Advanced Age | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 yr. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Dec. 16, 1956 , to Dec. 23, 1956 , that I last saw the deceased alive on Dec. 23, 1956 , and that death occurred at 7: A M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Ira M. Henderson M.D. | | | | ADDRESS (Street, city or town, state) Fairfield, Penna. | | | |
| DATE SIGNED 12-23-56 | | | | | | | |
| PHYSICIAN'S NAME (Type) Dr. Ira M. Henderson | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 12/26/1956 | | 22c. NAME OF CEMETERY OR CREMATORY St. Jacobs | | 22d. LOCATION (City, town, or county) (State) Fairfield RD #1 Adams Co. Pa. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE S. L. Allison | | | | ADDRESS Fairfield, Pa. | | 24a. REC'D BY REGISTRAR DATE 12-28-1956 | |
| | | | | 24b. REGISTRAR'S SIGNATURE | | | |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

Three for the Bureau

RECEIVED
JAN 10 1901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12509

CERTIFICATE OF DEATH

12488

Reg. Dist. No. 131

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY FREDERICK MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MD b. COUNTY FREDERICK | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BRADEN HILLS | | | | c. LENGTH OF STAY IN 1b 4 DAYS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WINDY BONA NURSING HOME | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last MARY LAVINIA URNER | | | | 4. DATE OF DEATH Month Day Year DEC 2 1956 | | | |
| 5. SEX FEMALE | | 6. COLOR OF RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH FEB. 16 1872 | |
| 9. AGE (In years last birthday) yrs. 84 | | 10. IF UNDER 1 YEAR Months Days Hours Min. 84 | | 11. BIRTHPLACE (State or foreign country) SOUTH CAROLINA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13. FATHER'S NAME JOSEPH W FLOYD | | | | 14. MOTHER'S MAIDEN NAME HARRIET F. PETTIT | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO --- | | 17. INFORMANT Address JOSEPH W. URNER FREDERICK MD | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 531X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Hypertension (c) Atherosclerosis | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 mo. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. --- 19 | | | | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from Jan 1 , 19 56 , to Dec 2 , 19 56 , that I last saw the deceased alive on Nov 28 , 19 56 , and that death occurred at 2:54 A.M., from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE A. A. Pearce M.D. | | | | ADDRESS (Street, city or town, state) Fredrick, Md | | | |
| DATE SIGNED | | | | | | | |
| PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, or other (Specify) BURIAL | | 22b. DATE THEREOF 12/4/56 | | 22c. NAME OF CEMETERY OR CREMATORY MT. OLIVET | | 22d. LOCATION (City, town, or county) (State) FREDERICK MD | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Clarence C. Gentry | | | | ADDRESS Fredrick Md | | 24a. REC'D BY REGISTRAR DATE 3 DEC 1956 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Elizabeth G. Hecks | | | |

2/10 1875
 10/10 1875

FREDERICK
 MD

1875

JOSEPH W. FLOYD
 HOUSE WIFE
 FEMALE WHITE
 MARY
 LAMINA CRNER
 DEC 2 20
 FEB. 10 1875
 SOUTH CAROLINA U.S.A
 HARRIET F. FLETCHER
 JOSEPH W. FLOYD
 FREDERICK MD
 1875

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12479
CERTIFICATE OF DEATH

12489

Reg. Dist. No. 131

| | | | | | | | |
|---|----------------------------------|---|--|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | | c. LENGTH OF STAY IN 1b Lifetime | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 122 East Seventh Street | | | | d. STREET ADDRESS 122 East Seventh Street | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First OLIVIA Middle M. Last WELLER | | | | 4. DATE OF DEATH Month December Day 7 Year 19 56 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH December 11, 1857 | | 9. AGE (In years last birthday) yrs 98 | IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own home | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Alfred Staley | | | | 14. MOTHER'S MAIDEN NAME Susan Shook | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Address Mr. Frank A. Weller - Mount Airy, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Intertrochanteric fracture upper hip. | | | | | | INTERVAL BETWEEN ONSET AND DEATH 7 1/2 | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. g. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Dec 6, 1956 to Dec 7, 1956 , that I last saw the deceased alive on Dec 6, 1956 , and that death occurred at 5:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Frederick Md. DATE SIGNED 12/8/56 | | | | | | | |
| ACTUAL SIGNATURE H. F. Kline | | M.D. Frederick Md. | | | | | |
| PHYSICIAN'S NAME (Type) Dr. H. F. Kline | | 7 North Market Street - Frederick, Maryland | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Buried | | 22b. DATE THEREOF 12/10/56 | | 22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery | | 22d. LOCATION (City, town, or county) (State) Frederick, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE C. E. Cline & Son | | | | ADDRESS Frederick - Md. | | 24a. REC'D BY REGISTRAR DATE 11 Dec. 1956 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Eligabeth G. Hecks | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

EC 10 1956

RECEIVED
JUL 10 1956

12480 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 CERTIFICATE OF DEATH

Reg. Dist. No. 12491

| | | | | | | | |
|---|----------------------------------|---|---|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | c. LENGTH OF STAY IN 1b 30 years | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital | | | | d. STREET ADDRESS 506 North Bentz Street | | | |
| 3. NAME OF DECEASED (Type or print) First CHARLES Middle WESLEY Last WETZEL | | | | 4. DATE OF DEATH Month December Day 22 Year 19 56 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH February 4, 1880 | | 9. AGE (In years last birthday) 76 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Day | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Henry Wetzel | | | | 14. MOTHER'S MAIDEN NAME Mary Naill | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or date of service) No | | 16. SOCIAL SECURITY NO. 214-10-2922 | | 17. INFORMANT Mr. Sterling J. Wetzel - Rt. 5, Frederick, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) fracture femur DUE TO (b) Uremia DUE TO (c) Pylonephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | INTERVAL BETWEEN ONSET AND DEATH days weeks yr | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. s. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 12/21, 1956 , to 12/22, 1956 , that I last saw the deceased alive on 12/21, 1956 , and that death occurred at 12:45 AM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE James B. Thomas | | | | ADDRESS (Street, city or town, state) Frederick, Md. | | | |
| PHYSICIAN'S NAME (Type) C. E. Cline & Son - Frederick - Md. | | | | DATE SIGNED 12/24/56 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Dec. 24, 1956 | | 22c. NAME OF CEMETERY OR CREMATORY Linganor Cemetery | | 22d. LOCATION (City, town, or county) (State) Nr. Unionville Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. C. E. Cline & Son - Frederick - Md. | | | | 24a. REC'D BY REGISTRAR DATE 24 Dec 1956 | | 24b. REGISTRAR'S SIGNATURE Elizabeth G. Herb | |

U.S. BUREAU OF

1901

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12484

CERTIFICATE OF DEATH

12491

Reg. Dist. No.

| | | | | | | | |
|--|----------------------------------|---|---------------------------------------|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 112 West "C" | | | | d. STREET ADDRESS 112 West "C" | | | |
| 3. NAME OF DECEASED (Type or print) First Walter Middle Christ Last Wheeler | | | | 4. DATE OF DEATH Month 12 Day 5 Year 1956 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10-17-1887 | 9. AGE (In years last birthday) yrs. 69 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Engineer | | 10b. KIND OF BUSINESS OR INDUSTRY B. & O. R.R. Co | | 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Anderson Wheeler | | | | 14. MOTHER'S MAIDEN NAME Lula C. Painter | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 705-10-0003 | | 17. INFORMANT Mrs. Margaret Wheeler, Brunswick, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Angina Pectoris 420.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | INTERVAL BETWEEN ONSET AND DEATH 10 7/8 | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 12/5/56 to 12/5/56 , that I last saw the deceased alive on 12/5/56 and that death occurred at M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE J.G.F. Smith | | | | DATE SIGNED 12/7/56 | | | |
| PHYSICIAN'S NAME (Type) J.G.F. Smith | | | | ADDRESS (Street, city or town, state) Brunswick, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 12-8-1956 | | 22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet | | 22d. LOCATION (City, town, or county) (State) Frederick, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE B. L. Zeit | | | | ADDRESS Brunswick, Maryland | | 24a. REC'D BY REGISTRAR DATE 12/10/56 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Regina Barker | | | |

STANDARD

1966

1966

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12492

12481

| | | | |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) b. CITY OR TOWN Chatham St. c. COUNTY Lynn, Massachusetts | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lynn, Massachusetts | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital | | d. STREET ADDRESS Chatham St. | |
| 3. NAME OF DECEASED (Type or print) Kenneth D. Wilson | | 4. DATE OF DEATH Month Dec. Day 9, Year 56 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9/18/22 |
| 9. AGE (In years last birthday) 33 yrs. | | IF UNDER 1 YEAR Months 3 Days 15 | IF UNDER 24 HRS Hours 15 Min. 00 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman | | 10b. KIND OF BUSINESS OR INDUSTRY Clark & Cook | |
| 11. BIRTHPLACE (State or foreign country) Massachusetts | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Walter Wilson | | 14. MOTHER'S MAIDEN NAME Elsie Campbell | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) 2 W. War | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Mrs. Florence A. Wilson, Lynn, Mass | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema DUE TO Atelectasis; fractured sternum; cerebral concussion Conditions, if any, which gave rise to immediate cause (b) concussion (c) concussion DUE TO concussion cause last. | | INTERVAL BETWEEN ONSET AND DEATH 5 hrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Car ran into back of tractor-trailer | |
| 20c. TIME OF INJURY Hour 2:50 o. m. 12/7/56 p. m. | | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route #40 | | 20f. (City or town) Carroll (State) Md. | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE B. O. Thomas | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Bernard O. Thomas, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Shipment | | 22b. DATE THEREOF 12/10/56 | |
| 22c. NAME OF CEMETERY OR CREMATORY Lynn, Mass | | 22d. LOCATION (City, town, or county) (State) Lynn, Mass | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Dalley's Funeral Home, Fred, Md. | | 24a. REC'D BY REGISTRAR 10 Dec 1956 | |
| | | 24b. REGISTRAR'S SIGNATURE Elizabeth H. Hach | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

DEC 11 1956

BUREAU V. S.

12482

CERTIFICATE OF DEATH

Reg. Dist. No. 131

| | | | | | | | |
|--|------------------------------|--|--|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> | | | | c. LENGTH OF STAY IN 1b <u>17 years</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>500 E. Patrick St.</u> | | | | d. STREET ADDRESS <u>500 E. Patrick St.</u> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Amelia Catherine Wolff</u> | | | | 4. DATE OF DEATH Month Day Year <u>Dec. 21 1956</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>OCT. 10, 1867</u> | 9. AGE (In years last birthday) <u>89 yrs.</u> | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u> | | 11. BIRTHPLACE (State or foreign country) <u>HANOVER PENNIA.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Elisha Blocher</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Catherine Forney</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | | | 16. SOCIAL SECURITY NO <u>NONE</u> | | | |
| 17. INFORMANT <u>Mr. Edna Zell</u> | | | | Address <u>500 E. Patrick St. Frederick Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1045</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from <u>Dec 16, 1956</u> to <u>Dec 16, 1956</u> , that I last saw the deceased alive on <u>Dec 16, 1956</u> , and that death occurred at <u>3:30 AM</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>H. F. Kline</u> | | | | DATE SIGNED <u>Dec 21 1956</u> | | | |
| PHYSICIAN'S NAME (Type) <u>H. F. Kline, M. D.</u> | | | | ADDRESS <u>7 N. Market St., Frederick, Md.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>24 Dec 1956</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>HANOVER, YORK CO. PENNIA.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Etchison & Son, Frederick, Maryland</u> | | | | 24a. REC'D BY REGISTRAR <u>DATE 24 Dec 1956</u> | | 24b. REGISTRAR'S SIGNATURE <u>Elizabeth H. Hark</u> | |

DOMINIC V. S.

DEC 1950

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12510

CERTIFICATE OF DEATH

12494

Reg. Dist. No. 131

| | | | | | | | |
|---|-------------------------------|--|--------------------------------------|--|-----------------|--|------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>FREDERICK</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL (HARMONY GROVE)</u> | | | | c. LENGTH OF STAY IN 1b <u>88 yrs</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FREDERICK ROUTE 1</u> | | | | e. STREET ADDRESS <u>FREDERICK ROUTE 1</u> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY WILLETTE WORMAN</u> | | | | 4. DATE OF DEATH Month Day Year <u>DEC 19 1956</u> | | | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>JULY 29 1868</u> | 9. AGE (In years last birthday) <u>88</u> yrs. | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE REPAIR</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>MD</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | |
| 13. FATHER'S NAME <u>WYD WORMAN</u> | | | | 14. MOTHER'S MAIDEN NAME <u>MARY E. GITTERER</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | 17. INFORMANT Address <u>FAMILY RECORD ROUTE #1</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line or (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebrovascular accident</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>days</u> <u>weeks</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) _____ (County) _____ (State) _____ | | | | 20g. (City or town) _____ (County) _____ (State) _____ | | | |
| 21. I certify that I attended the deceased from <u>1952</u> to <u>12/19, 1956</u> , that I last saw the deceased alive on <u>12/13, 1956</u> , and that death occurred at <u>2:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>James B. Thomas, M.D.</u> <u>Frederick, Md.</u> PHYSICIAN'S NAME (Type) _____ | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>12/21/56</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET</u> | | 22d. LOCATION (City, town, or county) (State) <u>FREDERICK MD</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Harold B. Gentry</u> ADDRESS <u>Frederick, Md.</u> | | | | 24a. REC'D BY REGISTRAR <u>DATE 19 Dec 1956</u> | | 24b. REGISTRAR'S SIGNATURE <u>Elizabeth G. Heck</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WISCONSIN STATE DEPARTMENT OF HEALTH—DIVISION 10

1956 17 231

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12511

CERTIFICATE OF DEATH

Reg. Dist. No. 139

12495

| | | | | | | | |
|---|--|-----------------------------------|--|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cullen | | | | c. LENGTH OF STAY IN 1b 7 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Big Pool 21X-2. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Victor Cullen State Hospital | | | | d. STREET ADDRESS Big Pool | | | |
| 3. NAME OF DECEASED (Type or print) First Nellie Middle Zimmerman Last Zimmerman | | | | 4. DATE OF DEATH Month December Day 23 Year 1956 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH October 19, 1909 | |
| | | | | 9. AGE (In years last birthday) 47 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| | | | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Charles Kaylor | | | | 14. MOTHER'S MAIDEN NAME Zeta Murray | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. 220-16-3598 | | 17. INFORMANT Address Mrs. Betty Decker, Daughter, Big Pool, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 002X DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 8 yrs. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from December 16, 1956 , to December 23, 1956 , that I last saw the deceased alive on December 23, 1956 , and that death occurred at 8:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cullen, Maryland DATE SIGNED December 23, 1956 | | | | | | | |
| ACTUAL SIGNATURE I. B. Lyon M.D. Cullen, Maryland | | | | DATE SIGNED December 23, 1956 | | | |
| PHYSICIAN'S NAME (Type) I. B. Lyon, M.D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 12-27-56 | | 22c. NAME OF CEMETERY OR CREMATORY Shanktown Cem. | | 22d. LOCATION (City, town, or county) (State) Near-Big Pool, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John F. Clark ADDRESS Ches Spring, Md | | | | 24a. REC'D BY REGISTRAR DATE 12/23/56 | | 24b. REGISTRAR'S SIGNATURE I. B. Lyon | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 3

DEC 31 1956

RECEIVED